# FROM "DISGRACEFUL CARELESSNESS" TO "INTELLIGENT PRECAUTION": ACCIDENTS AND THE PUBLIC CHILD IN ENGLISH CANADA, 1900-1950

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*Highlighting how medical professionals in English Canada understood accidents in childhood, this article explores the emergence of the idea of a "public child" throughout the course of the twentieth century. It asks how shifts in attitudes toward public health, domesticity, race, and gender shaped ideas about children, their safety, and their protection. The medicalized construction of a public child helped foster a more recognizable sense of community responsibility for the well-being of particular children at the same time as it increased and deepened the surveillance of families and parents. Although the management of children has always been a task ascribed primarily to women, the early twentieth century witnessed a new interest in categorizing children, whether as infants, workers, or students, as public health and safety risks worthy of public attention.*

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In his treatise on the "management of children," first published around the middle of the nineteenth century and reprinted in countries around the world, Pye Henry Chavasse, a British medical doctor, was unequivocal about the causes, and prevention, of accidents. "How can a mother prevent her child from having an accident," Chavasse asked in anticipation of his reader's pressing question,

> by strict supervision over him [*sic*] on her own part, and by not permitting her child to be left to the tender mercies of servants; by not allowing him to play with fire, to swing over banisters, and to have knives and playthings of a dangerous character . . . and

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> above all, and before all, insisting, lovingly, affectionately, but firmly, upon implicit obedience.

He went on to matter-of-factly conclude, "Accidents generally arise from one of three causes, namely, either from wilful disobedience, or from gross carelessness, or from downright folly."[1]

Chavasse's words of wisdom reflect a great deal about mid-nineteenth-century attitudes toward children and accidents among well-to-do British. A mother's forceful vigilance kept children accident free just as her weakness and incompetence (or unnatural neglect) surely did the opposite. Chavasse's characterizations of the nature of risk and prevention aptly demonstrate what historians John Burnham, Joel Tarr, and Mark Tebeau have identified as a nineteenth-century tendency to hold "safety" as a private trust—one very much shaped by traditional gendered thinking that linked women with all things domestic, including, quite centrally, children.[2]

Scholars have argued that by the turn of the nineteenth century in the North American and European contexts, responsibility for children's health became a matter of increasing *public* importance. David Armstrong and Neil Sutherland, for example, identified the increasing profile of public health professionals as one explanation for the creation of new concern around levels of infant mortality during the late nineteenth century.[3] Likewise, John Burnham has demonstrated the role of public safety professionals, particularly after World War II, in shifting blame for childhood accidents from the home to the public sphere.[4] Although the management of children has never ceased to be a task ascribed primarily to women, the early twentieth century witnessed a new interest in categorizing children, whether as infants, workers, or students, as public health and safety risks worthy of public attention.

I argue here that changes in health professionals' understanding of, and interaction with, accidents in childhood during the turn of the twentieth century in English Canada produced a child who was knowable in new ways. This knowledge work around whom Viviana Zelizer has called the "modern child" also gave rise to a medicalized "public child." The identification and protection of this public child in turn shifted attitudes toward children.[5] What do I mean by the *public child* in this context? The term signifies a child constructed through medical discourses of protection, prevention, and statistical attention. Although women as mothers continued to be chastised for accidental harm to children, increased public health attention helped foster a more recognizable sense of community responsibility for the well-being of particular children at the same time as it increased and deepened the surveillance of individual families and parents. For better and worse, the public child who needed protection from, and education about, accidents gave health professionals new kinds of influence in individual children's lives. This new dynamic, however, largely ignored children and families outside urban and middle-class settings. Testimony from rural and working children, in particular, demonstrates that the construction of a public child was decidedly selective. To explore these developments, I focus on conventional medicine's response to childhood accidents in English Canada during the course of the twentieth century. Preventing particular children from accidental harm or death, a growing focus of health work during the period, conjured up new categories of children, new critiques of parenting work and of children's behavior, and new spaces for health professionals to construct the public child.

Scholars in other contexts have focused on the consequences of medicine's preventative orientation for the surveillance of families and, in particular, for women as mothers.[6] What has garnered less attention is what this kind of knowledge production around an increasingly medicalized public child meant for attitudes toward youngsters. Moments of crisis prompted by child injury or death and responses to these tragedies reveal a matrix of beliefs and values about "proper" childhoods, "proper" parenting, and the role of communities in protecting and, indeed, constructing ways of knowing children. Equally instructive, however, are the silences surrounding the experiences of particular children. Michel Foucault has argued, "The most insightful way to understand society is to consider it from the perspective of the professions that emerged to contain its failures."[7] My focus on childhood accidents as particular kinds of failures—whether of providence or prevention—reveals how the state and its representatives shaped attitudes toward children that endure in our own time.

## DOMESTIC INADEQUACIES AND THE ACCIDENTAL CHILD

Early advice literature in books either produced in or widely circulated in English Canada anticipated that children would hurt themselves and that parents, particularly mothers, were culpable for any injury. The discussion of accidental harm centered on domestic inadequacies and the character flaws of parents. Writing for parents of young children at the turn of the century, Toronto-based nurse Reta Gray pronounced that death among children "is undoubtedly largely the result of ignorance regarding their proper care."[8] Of accidents in upper-class homes, Pye Henry Chavasse reminded mothers that their trust in servants could be naively misplaced: "A nurse frequently, when she has dropped her little charge is afraid to tell her mistress; the consequences might then be deplorable."[9] The taken-for-granted inadequacies of working-class families offered other obvious explanations for mishaps:

> A poor person's child is, from the unavoidable absence of the mother, sometimes shut up in the kitchen by himself [*sic*] and being very thirsty, and no other water being at hand, he is tempted, in his ignorance, to drink from the tea-kettle: If the water be unfortunately boiling, if will most likely prove to him to be a fatal draught![10]

Whatever the social location, maternal responsibility for accidental harm remained largely the same.

When accidents occurred, initial responses were largely private: mothers, always the first line of defense, treated their children in their homes using various remedies. If a child suffered a burn, for example, mothers were told to apply a thick coating of flour or unsalted lard to the wound. Should a child swallow opium, a strong mustard emetic—forced down the throat if need be—would induce vomiting. If such action failed to produce the desired results, mothers were to tickle the throat with a feather, force the little patient to drink large quantities of warm water, and, above all else, keep the child awake.[11] If a child coughed up bright red frothy blood due to poisoning, a teaspoon of brandy in very little water was to be drunk, or a steaming mixture of boiling water and turpentine was to be inhaled. Readers were reassured, one presumes not always appropriately, by suggestions that "there is seldom immediate danger."[12] With significant presumptions regarding mothers' ability to correctly identify a child's con-

dition, advice writers suggested that doctors be summoned only if conditions worsened.

Although accidental death or harm in childhood was acknowledged as tragic and regrettable in the early twentieth century, its discussion largely offered opportunities for medical experts to pontificate on the management or, more properly, mismanagement of individual children and families. It was a discourse shaped by class. The vulnerability of working children to accidental harm, although considerable, was not in itself scripted as a "social problem." Child laborers in Canadian coal mines in the mid- to late Victorian era regularly faced accidental death or dismemberment. Boys were thrown from horses, smothered under coal piles, hit by machinery, and buried under collapsed mine roofs.[13] Although youngsters who worked in and around their homes were generally not as vulnerable to the dangers associated with industrial life, danger still lurked. A young Ottawa boy gathering wood chips outside a lumber mill in 1899 "succumbed to his youthful curiosity and wandered into the plant only to meet his death on an unguarded mechanical saw."[14] Farm work was also dangerous work for youngsters. As a young girl growing up on a Saskatchewan farm in the late 1880s, Maryanne Caswell prepared the family's fields with harrow and oxen. The animals regularly got away from her, leaving her hands scarred with burns.[15] The inappropriate use of children's labor, and incompetent and neglectful adult supervision, were rarely offered up as explanations for the vulnerability of working children. The inherent inadequacies of working-class families, and their children's inexperience and lack of attention, were instead identified as the causes of death or dismemberment.[16]

## THE EMERGING PUBLIC CHILD

By the turn of the twentieth century in English Canada, public health professionals, in particular, attempted to reorient the way children's accidental injury or death was understood and dealt with. This reorientation was deeply connected to the fight against high rates of infant mortality and, by the 1920s, to attempts to stamp out contagious diseases among youngsters.[17] The safeguarding of babies and youngsters from early death and then from diseases such as diphtheria, tuberculosis, and whooping cough was undertaken at the community level largely dependent on the public management of private health and welfare.[18] Vital statistics regarding children's birth dates and cause of death were gathered, well-baby clinics and breastfeeding aggressively promoted, public health nurse visits to individual family homes and regularized doctor's visits insisted on, immunizations recommended, school medical inspection implemented, and advice from medical experts increasingly made available for parents, mostly mothers.[19] The implementation of these complex and intertwined webs of surveillance made possible a public child who was in need of education about, and protection from, health and safety threats. Reporting on the new area of "child welfare work" at the 1915 convention of the Canadian Nurses Association in Winnipeg, Nora Moore wrote the following:

> I might, if time permitted, go into detail, but I am sure we are all convinced that real progress can be obtained by going backward, back to the school child, back to the ante-natal period, remembering always that the object is not to relieve the parents of their responsibility, but to raise the standard by removal of ignorance, negligence and indifference.[20]

Despite the expansion of efforts to protect children in more public ways, the inadequacies of individual families continued to link past and present. Like campaigns to reduce infant mortality, efforts to contain the spread of contagious diseases such as diphtheria on the part of provincial boards of health were fixated on making domestic habits accountable to a public standard. In a 1885 pamphlet entitled "Sanitary and Preventive Measures, Disinfectants, and How to Use Them," issued by the Halifax, Nova Scotia, Board of Health, citizens were warned that the "poison of diphtheria clings with great tenacity to rooms, houses, articles of furniture and clothing, and may occasion the disease even after the lapse of months."[21]

Despite public education campaigns shaped in good measure by concerns over working-class inadequacies, contagions and infections continued to account for a significant number of deaths and hospitalizations for English Canadian children. In the ten-year period between 1899 and 1909, for example, diphtheria, scarlet fever, measles, and typhoid fever accounted for the majority of pediatric admissions to Kingston General Hospital in Kingston, Ontario.[22] Infectious diseases like typhoid fever could flourish in pioneering conditions of early-twentieth-century Canada when hot water and soap were available only infrequently and only to the upper classes. At the age of ten in 1909, for example, Prairie artist Annora Brown and her sister Helen contracted typhoid fever while traveling from Ontario. She recalled the following:

> Nightmares! Blackness! I came back to a different world—a doctor's face as familiar as my father's—my mother's face, strained and sad, when I asked why Helen did not come to see me—a realization of death—long months when my life was bounded by bedroom walls—days when I was lifted from bed to try standing on legs that wobbled strangely underneath me—a day when I could stand without support.[23]

The effects of such diseases on children and their families were often unspeakably difficult. Nurses dealing with cases of whooping cough were told, for example, that "the spasmodic stage is most dangerous and troublesome to the patient and trying to the family. . . . [L]oss of breath, whooping and vomiting often leave the child exhausted, sweating and sometimes apparently dazed."[24]

It is important to note, however, that urban middle-class children of Anglo-Celtic background received the most attention. The public child emerging in the discourses of health professionals was white, lived in a major city, and was most often middle class. First Nations peoples in the province of British Columbia continued to suffer from neglect into the 1920s and beyond. Testifying to the racialized specificity of "public" health, officials in the 1930s reported that "infectious diseases have shown a marked decrease," just as rates of death from tuberculosis among Native peoples were still five times that of whites.[25]

Despite the racialized exclusivity, the death rates due to infant mortality and contagions were understood to be declining for all Canadian children by the 1930s. Simultaneously, however, injury and death due to accidents surpassed all other causes as the major threat to the public child.[26] Canadian public health officials reported that for children aged five to fourteen years, death by accidental causes ranked first and was responsible for practically one death in every four that occurred.[27] Thus, as they had three decades previously, perceptions about the vulnerability of children's health, and the role of adults in protecting children, shifted with each new threat. There were important exceptions to this seemingly "public" campaign to protect English Canadian

children from accidental harm, however. Growing up in rural Manitoba in the late 1920s, Harold Draper remembered that as it had been earlier in the century, farming continued to take its toll on young, particularly male, farmhands. According to him,

> Most farm accidents were caused by carelessness, but the diverse skills demanded by farming generated a variety of injuries. The ax wielded by a neighbour's son who was felling trees for winter fuel glanced off a limb and embedded itself in his foot. . . . Falling or being thrown off horses was a cause of frequent fractures of the collarbone and forearm among boys and being kicked or stepped on by horses and cows of contusions of the legs and feet. Some injuries to boys were the result of successfully persuading their fathers to let them handle farm machinery before they had the skill and experience to do so safely.[28]

As Draper testified, accidental injury to children was in many rural settings continued with alarming regularity. Calls for more vigilance from public health professionals in urban centers seemed hopelessly out of touch with those families who depended on children's farm labor in spite of the risks associated with it. Likewise, as Victor Butler pointed out in his childhood memoirs, rural communities in remote areas of the country were not served by public health professionals, even though they were just as vulnerable to accidental harm. Growing up in Placentia Bay, Newfoundland, in the early years of the twentieth century, Butler remembered that families had to fend for themselves. After he had been accidentally hit with a small axe in his forehead, Butler was rushed to his grandmother's house by his father, Henry:

> My grandmother standing in the door entering the kitchen of her home, said, "Henry, bring the child in and lay him on the table." Taking a very fine sewing needle, bending it and threading it with white silk thread and dipping it in boiling water she said, "Henry, hold the child still." She soon had seven stitches in the cut. One can imagine how I screamed, the flesh not being deadened on my forehead.[29]

Despite the pain that Victor had to endure, it is also important to consider that the community was in fact very well served by lay medical practitioners, such as his grandmother, who had years of experience with community emergencies. This certainly seems to hold true for Ruth Cook, who grew up in a First Nations community near Prince Rupert in British Columbia in the 1930s. As she recalled, "You never had to worry if you got sick. You always had an uncle or an aunt, or the grandparents were there to lend a helping hand."[30]

## THE PUBLIC CHILD POST–WORLD WAR II: CODIFYING "PUBLIC"

By the late 1940s, doctors and nurses involved in children's health care focused on the importance of containing the incompetence of parents, particularly mothers. Strategies for accomplishing this goal were steeped in the discourse of prevention: community accident prevention through public safety education for children and adults. Still firmly based on white, middle-class, patriarchal, and urban assumptions, health professionals' research into the causes of accidents constructed the "typical" accident victim (a boy around the age of two) and the "typical" cause of accidents (neglectful par-

ents, particularly mothers), and criticized the role of new consumer products and services in endangering children. Although public health and safety professionals advocated for the increased enforcement of industry and government standards and regulations as protective measures against harm, the safety of the public child still began at home.[31] Health care professionals singled out adults as the main culprits:

> There is no doubt in anyone's mind that adults are at fault in the vast majority of cases. Who was driving the car? Who left the aspirin on a low shelf in the medicine cabinet? Who put the turpinetine [*sic*] in the "coke" bottle? Who left the revolver loaded?[32]

Even though Mary Wilson, public health nursing supervisor in Winnipeg, Manitoba, concluded in *The Canadian Nurse*, "The cooperation of doctors, parents, schools, hospitals, and health departments in promoting a continuous safety education program will help protect the child in our communities from needless death and injuries caused by accidents," professionals typically began their deconstruction of childhood accidents by focusing on mothers' behaviors.[33] Because statistics maintained that accidents in childhood involved young children in the home, the finger was relatively easy to point:

> Housewives should realize that volatile liquids, such as gasoline, benzine, naphtha, have a vapour that is heavier than air and seeks a lower level; that an open flame need not be near the volative liquid to cause trouble and that the vapour, when mixed with air, forms a high explosive as powerful as dynamite.[34]

Another public health nurse noted not so obliquely that "the highest accident rate is found in the preschool age group—a period during which children spend most of their time in the home environment, supposedly under care and supervision."[35]

Postwar health professionals presented the public child as particularly vulnerable to modern culture's, specifically adult culture's, obsession with convenience and consumerism. Reporting in the prestigious journals such as the *Canadian Medical Association Journal*, the *Canadian Public Health Journal*, and *The Canadian Nurse*, doctors and nurses took up the dangers to children posed by two developments in particular—the automobile and synthetic chemistry—as public health problems. One in every five or six persons killed in an automobile accident in 1934 was a child younger than fifteen years of age. This figure continued to rise well past World War II.[36] The research of doctors such as Ruth McDougall from Children's Hospital in Montreal on traffic accidents and children was typical in orientation and purpose. McDougall sought to tease out specific causes of car accidents involving children with the intent of advocating for more public sensitivity to the importance of safety education. She concluded that "responsibility lies both with parents to supervise and educate their children, and with drivers to observe school areas and pedestrian crossings, and to drive with caution in residential areas where children may be playing."[37]

The increasing availability of synthetic drugs and manufactured products for domestic use, such as prepackaged cleaning solutions, pest control poisons, painkillers of all kinds, and lead-based paints, likewise ushered in new and serious threats to public safety in the estimation of doctors. Modern consumer culture was often at odds with the well-being of the public child.[38] Between 1919 and 1933, for example, 135 children were admitted to Toronto's Hospital for Sick Children suffering from a wide

range of poisonings from synthetic drugs. In particular, newly available tablets such as A.B.S.&C (aloin, belladonna, strychnine, and cascara), Hinkle's Cascara, and Blaud Pill Compound were found to contain enough strychnine to cause poisoning with convulsions in children.[39] Dr. Alan Brown, one of Canada's most prominent pediatricians and the inventor of Pablum, lamented the increasing ease with which treatments for headaches and constipation were being marketed for domestic consumption.[40] Writing in the *Canadian Medical Association Journal* in the late 1950s, Dr. Henri Breault, a professor in the Faculty of Medicine at the University of Windsor in Windsor, Ontario, echoed Brown's sentiments. More bothersome in his estimation, however, was the manufacture of candy-coated headache tablets: "The greatest threat to children is the so-called 'babies' or 'infants' or 'children's' flavoured tablets. . . . Each one is sweeter, hence more palatable and more tempting, than the next competitor's."[41]

Whereas doctors such as Brown and Breault focused on the unscrupulous practices of drug companies, psychosocial explanations for harm gained increasing credence in discussions of accidents in childhood. Reflecting the rising popularity of psychology in postwar life, medical professionals introduced the idea that the public child could be an "accident-prone child."[42] Not yet attuned to the possibility of abuse, emergency room doctors and nurses often interpreted those children who were repeatedly treated for accidental injury as psychologically unstable. As nurse Irene Robertson wrote in the 1950s, "Often a child's unhappiness or lack of self-confidence may be the underlying cause of a series of what appear to be simply mishaps."[43] In his study of childhood accidents in Edmonton, Alberta, Dr. Neil Duncan suggested that in some cases,

> the thwarted or criticized child relieves his [*sic*] aggressions by striking at inanimate objects or by placing himself in a dangerous situation and thereby sustaining an injury. . . . A high percentage of accidents occur when the child is doing something forbidden by the parents.[44]

That children were thought to pass through particular developmental stages was likewise offered up as explanations for the accidental child. "From the stage of being solely dependent on adults for his [*sic*] needs," wrote Many Wilson, "the child moves into the stage of exploration and 'let's pretend'. . . . Children need freedom to move about but they also require safeguards such as gates at the head and foot of stairways."[45] Psychological theorizing thus provided a powerful new lens through which the accidental public child was interpreted and understood. It offered rational explanations for seemingly random mishaps.

Unfortunately, the clarity of this new psychological lens may have simultaneously obscured the existence of the physical abuse, and in particular the sexual abuse, of children. Traditional attitudes toward gender certainly played a central supporting role in this and were confirmed by emergency room statistics regarding accidents. Typically, boys outnumbered girls in frequency of accidental harm.[46] Given that young boys were understood by doctors to be more "impetuous, venturesome, and aggressive," they came to represent the typical accidental child. The "cautious little girl" was seen as far less vulnerable to falls, scrapes, bruises, and traffic hazards.[47] Her vulnerability to other kinds of harm, particularly sexual abuse, however, had the potential to be ignored or overlooked. At the end of a report on the causes of injuries to some 17,000 children brought to the emergency department of Toronto's Hospital for Sick Children in 1962, J. Arthur Keddy, director of Medical Records, noted that thirty cases of alleged sexual

assault against female children, ranging in age from seventeen months to fourteen years, had occurred in the past six months. Reflecting the silence and inaction that engulfed the sexual abuse of children at this time, Keddy concluded only, "One may well assume that some cases were unreported and the problem appears a serious one."[48]

## CONCLUSION

By the 1960s, doctors paid serious attention to the fact that "every year approximately 1500 Canadian children died as the result of accidents, a mortality greater than that due to the ten acute infectious diseases of childhood combined."[49] Summarizing what health professionals knew about the accidental public child, Dr. Neil Duncan concluded that

> one could forecast with a modicum of accuracy that the [accident] patient was a boy between the ages of one and two years who was playing at home under the supervision of his mother between the hours of 12 noon and 5 p.m. and that he had fallen and lacerated his head.
>
> If the accident was a poisoning, one would be right 17% of the time in saying that the child must have ingested some aspirin. If the news was of an accidental death, there would be a 50% probability of its being a traffic accident or a drowning.[50]

The specificity of Dr. Duncan's composite of the typical child accident victim—shaped by gender, class, race, and location—depended on knowledge work among health professionals during the course of the entire century. The discursive construction of the medicalized public child supported particular kinds of work, most notably in the area of accident prevention. From infant death to childhood contagions and to accidents, medicine's construction of, and response to, threats to children's health and safety shaped how children in English Canadian families throughout the twentieth century were understood, who was responsible for them, and how they were supposed to interact with the world around them. Health professionals advocated for new exchanges with children and with families based primarily on preventative education and firmly within extended webs of social surveillance.

By the end of the 1950s, doctors and nurses were calling for the production of children better able to read their surroundings, more aware of the dangers inherent in the world, and more apt to listen to concerned parents and doctors. The public child around whom this advocacy work was to take place, however, was not an aggregate of all Canadian children. As I have begun to suggest here, race, gender, class, and location played a part in building the public child's predominately white and male identity.

Medicine's focus on the statistics of accident prevention made children knowable in ways that differed from a previous focus on mothers' personal and domestic inadequacies. Inadequate mothers, and in particular inadequate working mothers, it is important to make clear, continued to receive blame for children's accidents. Echoing the gendered and class-based biases of Pye Henry Chavasse some seventy years previously, public health nurse Claire Halliday could still claim in 1953 that accidents occur "because children are frequently left with youthful sitters, while their mothers supplement the family income."[51] Despite this important continuity, accident prevention was contextualized in a more public way. A hundred years earlier, a child who ingested

opium-laced liniment, drank scalding hot water, or choked on a penny, according to leading medical men like Pye Henry Chavasse, was "wilfully disobedient" or the victim of "gross carelessness" or uncontrollable folly.[52] By the end of the 1950s, health professionals positioned their work differently: the protection of children and the prevention of accidents became public concerns, dependent on the alleviation of social inadequacies through public education. Enmeshed in webs of social surveillance shaped by race, class, and gender, this knowledge work helped initiate a newly public child. Systems of analysis for understanding children, including hygiene, poverty, housing, nutrition, and, significantly, accident prevention, simultaneously brought health professionals into the private and a particular child out to the public.

## ACKNOWLEDGMENT

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## NOTES

1. Pye Henry Chavasse, *Advice to a Mother on the Management of Her Children and on the Treatment on the Moment of Some of Their More Pressing Illnesses and Accidents* (Toronto: Willing and Williamson, 1880), 251.

2. John C. Burnham, "Why Did the Infants and Toddlers Die? Shifts in Americans' Ideas of Responsibility for Accidents: From Blaming Mom to Engineering," *Journal of Social History* 29, no. 4 (Summer 1996): 817-37; and Joel A. Tarr and Mark Tebeau, "Managing Danger in the Home Environment, 1900-1940," *Journal of Social History* 29, no. 4 (Summer 1996): 797-816.

3. David Armstrong, *Political Anatomy of the Body: Medical Knowledge in the 20th Century (Cambridge: Cambridge University Press, 1983);* David Armstrong, "The Invention of Infant Mortality," *Sociology of Health and Illness* 8 (1986): 211-32; David Armstrong, "Public Health Spaces and the Fabrication of Identity," *Sociology* 27, no. 3 (August 1993): 393-410; and Neil Sutherland, "'Education . . . Carried on Principally in the Home': The Campaign to Reduce Infant Mortality, 1895-1920," in *Children in English-Canadian Society: Framing the Twentieth-Century Consensus* (Toronto: University of Toronto Press, 1976), 56-70.

4. Burnham, "Why Did the Infants and Toddlers Die?" 817-37.

5. Zelizer argued that the rhetoric about children's value as laborers and contributors to the family coffers was replaced by their supposed heightened sentimental value. Viviana Zelizer, *Pricing the Priceless Child: The Changing Social Value of Children* (New York: Basic Books, 1985).

6. See Wendy Mitchinson, *Giving Birth in Canada, 1900-1950* (Toronto: University of Toronto Press, 2002); Cindy Comacchio, *"Nations Are Built of Babies": Saving Ontario's Mothers and Children, 1900-1940* (Montreal: McGill-Queen's University Press, 1993); and Katherine Arnup, *Education for Motherhood: Advice to Mothers in Twentieth Century Canada* (Toronto: University of Toronto Press, 1994).

7. Cited in T. M. Skrtic, *Behind Special Education: A Critical Analysis of Professional Culture and School Organization* (Denver: Love Publishing, 1991), 24.

8. Reta Gray, *Queer Questions Quaintly Answered; or, Creative Mysteries Made Plain to Children* (Toronto: J. L. Nichols & Co., 1899), 245.

9. Chavasse, *Advice to a Mother*, 236.

10. Ibid., 244.

11. Ibid., 239, 241, 249.

12. Elisabeth Robinson Scovil, *The Care of Children* (Philadelphia: H. Altemus, 1894), 290. Scovil was the superintendent of the Newport Hospital and an associate editor of the *Ladies Home Journal*. Her advice manual was circulated widely in Canada.

13. Robert McIntosh, "'Grotesque Faces and Figures': Child Labourers and Coal Mining Technology in Victorian Canada," *Scientia Canadensis* 12, no. 2 (Fall/Winter 1988): 108.

14. John Bullen, "Hidden Workers: Child Labour and the Family Economy in Late Nineteenth-Century Urban Ontario," *Labour/Le Travail* 18 (Fall 1986): 167.

15. Maryanne Caswell, *Pioneer Girl* (Toronto: McGraw-Hill, 1968), 57-58. Claude Baity was ten years old in 1889 when he slipped through the poles in the bottom of the family's haystack in northern British Columbia and had his leg mashed on a stump. Earl Shaw Baity, *I Remember Chilako* (Prince George, B.C.: Prince George Publishers, 1978), 153.

16. Bullen, "Hidden Workers," 167-183.

17. For a discussion of infant mortality as invented, see Armstrong, "The Invention of Infant Mortality," 211-32.

18. H. A. Ansley, "State of Health of People of Canada, 1945," *Canadian Journal of Public Health* 38, no. 6 (June 1947), 273. By the 1920s, 102 infants per 1,000 live births died. In 1931, 85 out of every 1,000 infants died. By 1941, the rate dropped to 60, and by 1945, the rate of infant death had declined further to 51 out of every 1,000 live births.

19. Comacchio, *"Nations Are Built of Babies"*; Sutherland, "'Education . . . Carried on Principally in the Home,'" 56-70; and J. H. B. Grant, "Immunization of Children," *Canadian Medical Association Journal* 55, no. 5 (November 1946): 494.

20. Nora Moore, "Child Welfare Work," *Canadian Nurse* 12, no. 11 (November 1916): 635.

21. Board of Health of Halifax, Nova Scotia, *Sanitary and Preventive Measures, Disinfectants, and How to Use Them. What May Be Done by the Public to Guard against Contagious or Infectious Diseases* (Halifax, Board of Health of Halifax, 1885).

22. M. W. Partington, "Paediatric Admissions to Kingston General Hospital, Kingston, Ontario (1899-1909)," *Families* 22, no. 1 (1983): 33-46. A total of 846 cases were admitted: measles (57), diphtheria (338), scarlet fever (372), and typhoid fever (79). Of this number, 34 children died. The next most frequently cited category for pediatric admission, at 385 admissions, was for the infection and removal of tonsils and adenoids.

23. Annora Brown, *Sketches from Life: Annora Brown* (Edmonton, Alb.: Hurtig, 1981), 20-21.

24. Cameron Stewart, "Whooping Cough," *Canadian Nurse* 34, no. 3 (March 1938): 125.

25. See Province of British Columbia, *Thirty-Fourth Report of the Provincial Board of Health* (Victoria, B.C.: King's Printer, 1930), R18-R19. In 1929, 31 percent of all deaths in the Native community were due to tuberculosis compared to 6.7 percent in the white community. On the devastation to Native communities caused by tuberculosis, see Mary Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950* (Vancouver: University of British Columbia Press, 1998).

26. Outbreaks of contagious and infectious diseases continued to occur, albeit with decreasing frequency and severity. As William Macklon remembered from his Saskatoon, Saskatchewan, boyhood in the 1920s, "At school, we students broke up into little cliques which spent recess covertly watching each other for 'peelers.' . . . [I]t was well known that peeling skin was a sure sign of the scarlet plaque." William C. Macklon, *The Fledging Years* (Saskatoon, Sask.: Western Producer Prairie Books, 1990), 17-18.

27. Between 1926 and 1930, infectious diseases accounted for 73 percent of deaths among children between the ages of one and four. During this same period, accidents accounted for 9 percent of deaths of similarly aged children. By the end of the 1950s, this trend was reversing. In 1961, infectious diseases accounted for 27 percent of children's deaths in the first four years of life. Accidental death accounted for 37 percent of children's deaths. This figure would rise to 42 percent by the 1980s. Margaret King, John Gartrell and Frank Trovato, "Early Childhood Mortality," *Canadian Social Trends* 21 (Summer 1991): 6-10.

28. Harold Draper, *Growing Up in Manitoba* (Regina, Sask.: Canadian Plains Research, 1998), 101.

29. Victor Butler, "My Life," in Wilfred W. Wareham, ed., *The Little Nord Easter: Reminiscences of a Placentia Bayman* (St. John's, Nfld.: Breakwater, 1980), 13.

30. Dorothy Haegert, *Children of the First Nations* (Vancouver, B.C.: Tillacum Library, 1983), 24.

31. See, for example, A. Hardisty Sellers, "Accidents and the Public Health with Particular Reference to Automobile Accidents," *Canadian Public Health Journal* 27, no. 3 (March 1936), 133. See also Rodney S. Fowler, "Accidents in Childhood: A Survey of 150 Cases in Private Paediatric Practise," *Canadian Medical Association Journal* 79 (August 15, 1958): 241-46; and Ruth McDougall, "Traffic Accidents to Children," *Canadian Medical Association Journal* 82, no. 2 (January 9, 1960): 61-65.

32. Neil F. Duncan, "Accidents in Childhood," *Canadian Medical Association Journal* 78, no. 8 (April 1958): 578.

33. Mary Wilson, "Accident Prevention in Infants and Preschool Children," *Canadian Nurse* 50, no. 4 (April 1954): 290-91.

34. Wilson, "Accident Prevention in Infants and Preschool Children," 289.

35. Dorothy J. Guild, "The Promotion of Safety: The Role of the Public Health Nurse," *Canadian Nurse* 51, no. 6 (June 1955): 456.

36. C. Collins-Williams, "Accidents in Children," *Canadian Medical Association Journal* 65, no. 6 (December 1951): 534.

37. McDougall, "Traffic Accidents to Children," 64. See also Claire Halliday, "New Safety Container Prevents Poisoning Accidents," *Canadian Nurse* 49, no. 11 (1953): 852-54; Wilson, "Accident Prevention in Infants and Preschool Children," 287-91; Duncan, "Accidents in Childhood"; and Fred W. Jeffrey, "Death from Plastic Film," *Canadian Nurse* 55, no. 12 (December 1959): 1096-97.

38. C. M. Jephcott, "Lead in Certain Coloured Chalks and the Danger to Children," *Canadian Public Health Journal* 28, no. 8 (August 1937): 391-93.

39. John R. Ross and Alan Brown, "Poisonings Common in Children," *Canadian Public Health Journal* 26, no. 5 (May 1935): 238.

40. Ross and Brown, "Poisonings Common in Children," 286-87.

41. Henri J. Breault, "The Prevention of Acetylsalicylic Acid Poisonings," *Canadian Medical Association Journal* 79, no. 10 (November 1958): 826.

42. On the influence of popular psychology in postwar Canada, see Mona Gleason, *Normalizing the Ideal: Psychology, Schooling, and the Family in Postwar Canada* (Toronto: University of Toronto Press, 1999).

43. Irene M. Robertson, "Get Down to Brass Tacks: Prevent Home Accidents," *Canadian Nurse* 55, no. 12 (December 1959): 1098.

44. Duncan, "Accidents in Childhood," 578.

45. Wilson, "Accident Prevention in Infants and Preschool Children," 288.

46. See, for example, John H. Read, Eleanor J. Bradley, Joan D. Morison, David Lewall, and David Clarke, "The Epidemology and Prevention of Traffic Accidents Involving Child Pedestrians," *Canadian Medical Association Journal* 89, no. 14 (October 5, 1963): 695.

47. Read, Bradley, Morison, Lewall, and Clarke, "The Epidemology and Prevention of Traffic Accidents Involving Child Pedestrians."

48. J. Arthur Keddy, "Accidents in Childhood: A Report on 17,141 Accidents," *Canadian Medical Association Journal* 91, no. 13 (September 26, 1964): 670.

49. C. Collins-Williams, "Accidents in Children," *Canadian Medical Association Journal* 65, no. 6 (December 1951): 531.

50. Duncan, "Accidents in Childhood," 575-79.

51. Halliday, "New Safety Container Prevents Poisoning Accidents," 853.

52. Chavasse, *Advice to a Mother*, 251.